

		FOR OHF USE					

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2004  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2004)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037309

Facility Name: VANDALIA TERRACE

Address: 1610 HILLSBORO ROAD VANDALIA 62471  
Number City Zip Code

County: FAYETTE

Telephone Number: ( 618 ) 283-1434 Fax # ( 618 ) 283-2174

IDPA ID Number: 37-1282320

Date of Initial License for Current Owners: 08/01/91

Type of Ownership:

<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL
<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County
IRS Exemption Code		<input checked="" type="checkbox"/>	Corporation	<input type="checkbox"/>	Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:  
Name: BOB KAGDA Telephone Number: ( 847 ) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)		(Date)
	(Type or Print Name)	MELVIN SIEGEL	
	(Title)	PRESIDENT	
Paid Preparer	(Signed)	(SEE ATTACHED ACCOUNTANTS' REPORT)	
			(Date)
	(Print Name and Title)	BOB KAGDA PARTNER	
	(Firm Name & Address)	KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124	
	(Telephone)	( 847 ) 675-3585	Fax # ( 847 ) 675-5777
MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630			

Facility Name & ID Number VANDALIA TERRACE

# 0037309 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	79	Intermediate (ICF)	79	28,914	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	79	TOTALS	79	28,914	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	13,159	305		13,464	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,159	305		13,464	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 46.57%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 08/01/91

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 08/01/91 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☐ NO ☒ If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **VANDALIA TERRACE** # **0037309** Report Period Beginning: **01/01/2004** Ending: **12/31/2004**  
**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	67,893	5,240	3,936	77,069		77,069		77,069			1
2	Food Purchase		58,776		58,776		58,776		58,776			2
3	Housekeeping	22,295	4,858		27,153		27,153		27,153			3
4	Laundry	13,978	3,340		17,318		17,318		17,318			4
5	Heat and Other Utilities			46,795	46,795		46,795	921	47,716			5
6	Maintenance	26,809		22,185	48,994		48,994	(1,965)	47,029			6
7	Other (specify):*			2,801	2,801		2,801	62	2,863			7
8	<b>TOTAL General Services</b>	130,975	72,214	75,717	278,906		278,906	(982)	277,924			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			9,261	9,261		9,261		9,261			9
10	Nursing and Medical Records	357,648	8,730	4,068	370,446		370,446	5,318	375,764			10
10a	Therapy											10a
11	Activities	7,939	1,153	4,232	13,324		13,324	(2,340)	10,984			11
12	Social Services	23,975	1,542		25,517		25,517		25,517			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	389,562	11,425	17,561	418,548		418,548	2,978	421,526			16
	<b>C. General Administration</b>											
17	Administrative	47,962		3,000	50,962		50,962	849	51,811			17
18	Directors Fees											18
19	Professional Services			87,055	87,055		87,055	(63,985)	23,070			19
20	Dues, Fees, Subscriptions & Promotions			5,740	5,740		5,740	(1,498)	4,242			20
21	Clerical & General Office Expenses	22,531	4,087	14,223	40,841		40,841	24,639	65,480			21
22	Employee Benefits & Payroll Taxes			132,335	132,335		132,335		132,335			22
23	Inservice Training & Education			2,015	2,015		2,015	224	2,239			23
24	Travel and Seminar							3,923	3,923			24
25	Other Admin. Staff Transportation			4,888	4,888		4,888	2,990	7,878			25
26	Insurance-Prop.Liab.Malpractice			65,464	65,464		65,464	420	65,884			26
27	Other (specify):*			230	230		230	8,830	9,060			27
28	<b>TOTAL General Administration</b>	70,493	4,087	314,950	389,530		389,530	(23,608)	365,922			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	591,030	87,726	408,228	1,086,984		1,086,984	(21,612)	1,065,372			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	<b>DIETARY</b>		
	DIETITIAN CONSULTANT	XVIII B 35-2	3,936
	REPAIRS & MAINTENANCE		0
			0
			3,936
3	<b>HOUSEKEEPING</b>		
			0
			0
			0
4	<b>LAUNDRY</b>		
	EQUIPMENT REPAIRS & MAINTENANCE		0
			0
			0
5	<b>HEAT &amp; OTHER UTILITIES</b>		
	GAS HEAT		16,864
	ELECTRICITY		14,997
	WATER		13,370
	CABLE TV - LOBBY		1,564
			0
			46,795
6	<b>MAINTENANCE</b>		
	GROUNDS MAINTENANCE		0
	PAINTING & DECORATING		0
	BUILDING REPAIRS		0
	MAINTENANCE CONSULTANT		6,660
	EQUIPMENT MAINTENANCE & REPAIR		13,422
	ELEVATOR MAINTENANCE & REPAIR		0
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		0
	FIRE SERVICE		2,103
			0
			0
			0
			22,185
7	<b>OTHER</b>		
	SCAVENGER		2,801
	SECURITY SERVICE		0
			2,801
9	<b>MEDICAL DIRECTOR</b>		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	9,261
			9,261

LINE		SCHED REF	TOTAL
10	<b>NURSING</b>		
	CONTRACT NURSING	XVIII C 53-2	0
	LABORATORY & XRAY EXPENSE		0
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B 47-2	2,538
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0
	PHARMACY CONSULTANT	XVIII B 39-2	780
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	0
	GERIATRIC CONSULTANT	XVIII B 48-2	750
			0
			4,068
10a	<b>THERAPY</b>		
	PHYSICAL THERAPY SERVICES		0
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			0
11	<b>ACTIVITIES</b>		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	4,232
			0
			4,232
12	<b>SOCIAL SERVICES</b>		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	0
			0
			0
13	<b>NURSE AIDE TRAINING</b>		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	0	0
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B 3,000	3,000
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C 7,844	
	ADMINISTRATIVE CONSULTANTS	XIX C 4,632	
	PROFESSIONAL FEES	XIX C 13,744	
	BOOKKEEPING/ADMINISTRATIVE SERVICE	60,835	87,055
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F 0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F 118	
	EMPLOYEE WANT ADS	XIX F 443	
	CONTRIBUTIONS	VI 20 XIX F 780	
	DUES & SUBSCRIPTIONS	XIX F 3,266	
	LICENSES & PERMITS	XIX F 328	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F 0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F 0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F 0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F 805	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F 0	5,740
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	3,905	
	EQUIPMENT REPAIR & MAINTENANCE	0	
	OUTSIDE CLERICAL SERVICES	0	
	PENALTIES / OVERDRAFT CHARGES	VI 18 634	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	9,684	
	MESSENGER SERVICE	0	
		0	14,223

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D 45,176	
	UNEMPLOYMENT COMPENSATION	XIX D 16,492	
	WORKERS COMPENSATION INSURANCE	XIX D 24,737	
	HOSPITALIZATION INSURANCE	XIX D 44,136	
	EMPLOYEE BENEFITS - OTHER	XIX D 1,794	
	EMPLOYEE PHYSICAL EXAMS	XIX D 0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D 0	
	PENSION/PROFIT SHARING PLANS	XIX D 0	
	CHICAGO HEAD TAX	XIX D 0	132,335
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	2,015	2,015
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G 0	
	TRAVEL	XIX G 0	
		0	
		0	0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	4,888	4,888
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	65,464	65,464
27	OTHER		
	BAD DEBTS	VI 24 230	
			230

GRAND TOTAL COLUMN 3 OTHER 408,228

VANDALIA TERRACE  
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)  
12/31/2004

TOTAL FOOD PURCHASE	58,776	PATIENT MEALS	40392
LESS SALES TAX	0	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	58,776	TOTAL MEALS/YEAR	40392
TOTAL PATIENT CENSUS	13,464	NET FOOD	58776
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	40392
	-----		
TOTAL PATIENT MEALS	40392	COST PER MEAL	1.46
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		-----
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			4,323	4,323		4,323	13,574	17,897			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,925	1,925		1,925	26,758	28,683			32
33	Real Estate Taxes			21,331	21,331		21,331		21,331			33
34	Rent-Facility & Grounds			37,953	37,953		37,953	(35,215)	2,738			34
35	Rent-Equipment & Vehicles			7,965	7,965		7,965	3,151	11,116			35
36	Other (specify):*											36
37	TOTAL Ownership			73,497	73,497		73,497	8,268	81,765			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,372	43,372		43,372		43,372			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			43,372	43,372		43,372		43,372			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	591,030	87,726	525,097	1,203,853		1,203,853	(13,344)	1,190,509			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,075	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(634)	21		18
19	Entertainment		20		19
20	Contributions	(1,585)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(230)	27		24
25	Fund Raising, Advertising and Promotional	(118)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,492)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the  
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(11,852)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (11,852)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (13,344)		37

\*These costs are only allowable if they are necessary to meet minimum  
licensing standards. Attach a schedule detailing the items included  
on these lines.

C. Are the following expenses included in Sections A to D of pages 3  
and 4? If so, they should be reclassified into Section E. Please  
reference the line on which they appear before reclassification.  
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47



NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

## Summary A

**12/31/2004**

[illegible]

## Summary B

12/31/2004

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		ARC OF JACKSONVILLE	JACKSONVILLE	MAVIN	SKOKIE, IL	CONSULTING
		LITCHFIELD TERRACE	LITCHFIELD	ENTERPRISES, LTD.		BOOKKEEPING
SEE ATTACHED SCHEDULE		RIVER VIEW MANOR	LOVES PARK			
		PARKVIEW TERRACE	EAST MOLINE	MEVIN NURSING	SKOKIE, IL	REAL ESTATE
		GOLDEN TERRACE	JACKSONVILLE	ASSOC LTD		
		SPRINGFIELD TERRACE	SPRINGFIELD			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	MAINTENANCE CONSULTANT	\$ 6,660	MAVIN ENTERPRISES, LTD		\$	\$ (6,660)	1
2	V	10	PSYCHO-SOCIAL CONSULTANT	2,145				(2,145)	2
3	V	11	ACTIVITIES CONSULTANT	2,340				(2,340)	3
4	V	19	ADMIN. /BKBP. FEES	60,061				(60,061)	4
5	V	19	ADMIN. /CONSULT. FEES	4,632				(4,632)	5
6	V								6
7	V	5	ELECTRICITY/GAS				921	921	7
8	V	6	MAINTENANCE				4,695	4,695	8
9	V	7	SCAVENGER				62	62	9
10	V	10	PSYCH-SOCIAL & NURSING CONSULT				7,463	7,463	10
11	V	17	ADMINISTRATIVE SALARIES				849	849	11
12	V	19	PROFESSIONAL FEES				708	708	12
13	V	20	ADVERTISING				205	205	13
14	Total			\$ 75,838			\$ 14,903	\$ * (60,935)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	TOTAL OFFICE	\$	MAVIN ENTERPRISES, LTD.		\$ 25,273	\$ 25,273	15
16	V	23	SEMINARS				224	224	16
17	V	24	TRAVEL				3,923	3,923	17
18	V	25	TRANSPORTATION				2,990	2,990	18
19	V	27	EMPLOYEE BENEFITS				9,060	9,060	19
20	V	30	DEPRECIATION (SL)				214	214	20
21	V	32	INTEREST				100	100	21
22	V	34	OFFICE RENT				2,738	2,738	22
23	V	35	EQUIPMENT RENT				3,151	3,151	23
24	V	26	INSURANCE				420	420	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 48,093	\$ * 48,093	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	\$ 37,953	MELVIN NURSING ASSOC. LTD PARTNERSHIP		\$	(37,953)	15
16	V	30	DEPRECIATION				12,285	12,285	16
17	V	32	INTEREST				26,658	26,658	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 37,953			\$ 38,943	\$ * 990	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1  Name	2  Title	3  Function	4  Ownership Interest	5  Compensation Received From Other Nursing Homes*	6  Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7  Compensation Included in Costs for this Reporting Period**		8  Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5			SEE ATTACHED SCHEDULE								5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number VANDALIA TERRACE# 0037309 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization MAVIN ENTERPRISES, LTD.  
Street Address 3845 OAKTON  
City / State / Zip Code SKOKIE, IL 60076  
Phone Number ( 847 ) 679-0100  
Fax Number ( 847 ) 679-0647

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	ELECTRICITY/GAS	PATIENT DAYS	143,912	7	\$ 9,847	\$	13,464	\$ 921	1
2	6	MAINTENANCE	PATIENT DAYS	143,912	7	50,183	50,150	13,464	4,695	2
3	7	SCAVENGER	PATIENT DAYS	143,912	7	661		13,464	62	3
4	10	PSYCH-SOCIAL & NURSING	PATIENT DAYS	143,912	7	79,777		13,464	7,464	4
5	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	143,912	7	9,075	9,075	13,464	849	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	143,912	7	7,562		13,464	707	6
7	20	ADVERTISING	PATIENT DAYS	143,912	7	2,189		13,464	205	7
8	21	TOTAL OFFICE	PATIENT DAYS	143,912	7	270,128	213,321	13,464	25,272	8
9	23	SEMINARS	PATIENT DAYS	143,912	7	2,385		13,464	223	9
10	24	TRAVEL	PATIENT DAYS	143,912	7	41,923		13,464	3,922	10
11	25	TRANSPORTATION	PATIENT DAYS	143,912	7	31,958		13,464	2,990	11
12	27	EMPLOYEE BENEFITS	PATIENT DAYS	143,912	7	96,841		13,464	9,060	12
13	30	DEPRECIATION (SL)	PATIENT DAYS	143,912	7	2,285		13,464	214	13
14	32	INTEREST	PATIENT DAYS	143,912	7	1,072		13,464	100	14
15	34	OFFICE RENT	PATIENT DAYS	143,912	7	29,270		13,464	2,738	15
16	35	EQUIPMENT RENT	PATIENT DAYS	143,912	7	33,698		13,464	3,153	16
17	26	INSURANCE	PATIENT DAYS	143,912	7	4,498		13,464	421	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 673,352	\$ 272,546		\$ 62,996	25



IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10			
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense				
		YES	NO				Original	Balance							
	A. Directly Facility Related														
	Long-Term														
1	RELATED PARTY						\$					\$	1		
2	MAVIN NURSING ASSOC.												2		
3	BANK FINANCIAL		X	MORTGAGE	\$5,896.00	10/04/01		650,000	605,568	9/28/06	5.0000	26,658	3		
4													4		
5	MGMT ALLOCATION											100	5		
	Working Capital														
6	UNIVERSAL			INSURANCE FINANCE								1,925	6		
7													7		
8													8		
9	TOTAL Facility Related				\$5,896.00		\$	650,000	\$	605,568			\$	28,683	9
	B. Non-Facility Related*														
10													10		
11													11		
12													12		
13													13		
14	TOTAL Non-Facility Related						\$		\$			\$		14	
15	TOTALS (line 9+line14)						\$	650,000	\$	605,568			\$	28,683	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$    N/A                      Line #                     

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

## B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.

**\$ 20,772**

**\$ 20,947**

\$ 175

**\$ 21,156**

**(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**

**\$**

\_\_\_\_\_

**§**

\$	21,331
----	--------

Real Estate Tax Bill for Calendar Year:

1999	16,320	8
2000	18,199	9
2001	19,630	10
2002	20,772	11
2003	20,947	12

**ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL**

**THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.**

	<b>FOR OHF USE ONLY</b>	
13	FROM R. E. TAX STATEMENT FOR 2003 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

VANDALIA TERRACE

COUNTY

FAYETTE

FACILITY IDPH LICENSE NUMBER

0037309

CONTACT PERSON REGARDING THIS REPORT

BOB KAGDA

TELEPHONE ( 847 ) 675-3585

FAX #: ( 847 ) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	18-14-08-180-002	NURSING HOME	\$ 20,946.60	\$ 20,946.60
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 20,946.60	\$ 20,946.60

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

B. General Construction Type:

Exterior

BRICK

Frame

STEEL

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name &amp; ID Number VANDALIA TERRACE

# 0037309

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	79		1991		\$ 386,952	\$ 12,285	31.5	\$ 12,285	\$	\$ 154,478	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS		1991		17,600	559	20	880	321	10,868	9
10	VARIOUS		1992		992		20			992	10
11	VARIOUS		1993		4,216	108	20	211	103	2,408	11
12	VARIOUS		1994		15,024	385	20	751	366	7,673	12
13	VARIOUS		1995		2,096	54	20	105	51	986	13
14	ROOF REPAIRS		1996		2,450	63	20	123	60	1,107	14
15	ROOF REPAIRS		1996		4,120	106	20	206	100	1,854	15
16	ROOF REPAIRS		1996		4,295	110	20	215	105	1,863	16
17	INSTALLED NEW DURO-LAST ROOF		2000		54,300	1,975	27.5	1,975		8,888	17
18	INSTALLED NEW CARPETING IN FRONT LOBBY		2000		665	95	20	33	(62)	165	18
19	INSTALL A DOOR ACCESS SYSTEM		2001		11,503	418	27.5	418		1,463	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 504,213	\$ 16,158		\$ 17,202	\$ 1,044	\$ 192,745	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 29,823	\$ 450	\$ 481	\$ 31	8-10 YRS	\$ 27,105	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	MGMT ALLOCATION		214	214				74
75	TOTALS	\$ 29,823	\$ 664	\$ 695	\$ 31		\$ 27,105	75

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76	FACILITY	1991 DODGE CARAVAN	1991	\$ 19,088	\$	\$	\$		\$ 19,088
77									
78									
79									
80	TOTALS			\$ 19,088	\$	\$	\$		\$ 19,088

E. Summary of Care-Related Assets					1	2
		Reference				Amount
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	553,124
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	16,822
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	17,897
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	1,075
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	238,938

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.  
This amount was calculated by dividing the total amount to be amortized  
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: \$ 5,038 Description: SEE SCHEDULE ATTACHED  
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	1996 CHRYSLER VAN	\$ 244.00	\$ 2,927	17
18					18
19					19
20					20
21	TOTAL		\$ 244.00	\$ 2,927	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	\$
13.	/2006	\$
14.	/2007	\$

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.



A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☐

☐

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits			N/A				6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (55,746)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	327,691		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	41,819		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	210,743		8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 524,507	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	116,596		15
16	Equipment, at Historical Cost	49,576		16
17	Accumulated Depreciation (book methods)	(75,674)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	5,827		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 96,325	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 620,832	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 260,989	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	423,251		29
30	Accrued Salaries Payable	23,643		30
31	Accrued Taxes Payable (excluding real estate taxes)	73,582		31
32	Accrued Real Estate Taxes(Sch.IX-B)	21,156		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 802,621	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 802,621	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (181,789)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 620,832	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (194,638)	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	(984)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (195,622)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	13,833	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 13,833	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (181,789)	24 *

\* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,216,932	1
2	Discounts and Allowances for all Levels	( )	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,216,932	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	OTHER MISCELANEOUS	754	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 754	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,217,686	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	278,906	31
32	Health Care	418,548	32
33	General Administration	389,530	33
	B. Capital Expense		
34	Ownership	73,497	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	43,372	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,203,853	40
41	Income before Income Taxes (line 30 minus line 40)**	13,833	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 13,833	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.  
TAX RETURN PREPARED ON CASH BASIS

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	858	962	\$ 15,353	\$ 15.96	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,714	1,762	27,164	15.42	3
4	Licensed Practical Nurses	8,294	8,949	134,943	15.08	4
5	Nurse Aides & Orderlies	14,528	15,245	122,543	8.04	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	864	980	7,939	8.10	10
11	Social Service Workers	2,548	2,594	23,975	9.24	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	8,928	9,472	67,893	7.17	15
16	Dishwashers					16
17	Maintenance Workers	1,939	2,155	26,809	12.44	17
18	Housekeepers	3,408	3,808	22,295	5.85	18
19	Laundry	1,550	1,740	13,978	8.03	19
20	Administrator	1,856	2,035	47,962	23.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,495	1,663	22,531	13.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) SEE ATTACHED	3,010	3,237	57,645	17.81	33
34	TOTAL (lines 1 - 33)	50,992	54,602	\$ 591,030 *	\$ 10.82	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 3,936	1-3	35
36	Medical Director	O	9,261	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	780	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	4,232	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47	PSYCHO-SOCIAL CONSULTANT		2,538	10-3	47
48	GERIATRIC CONSULTANT		750	10-3	48
49	TOTAL (lines 35 - 48)		\$ 21,497		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	N/A	\$ 0	10-3	50
51	Licensed Practical Nurses	N/A	0	10-3	51
52	Nurse Aides	N/A	0	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

Facility Name & ID Number				STATE OF ILLINOIS				Page 21				
VANDALIA TERRACE				# 0037309				Report Period Beginning: 01/01/2004				
								Ending: 12/31/2004				
XIX. SUPPORT SCHEDULES												
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions				
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount		
MARSHA JACOBS		ADMIN	0	\$ 10,147	Workers' Compensation Insurance		\$ 24,737	IDPH License Fee		\$		
BYRON WITT		ADMIN	0	37,815	Unemployment Compensation Insurance		16,492	Advertising: Employee Recruitment		443		
					FICA Taxes		45,176	Health Care Worker Background Check		0		
					Employee Health Insurance		44,136	(Indicate # of checks performed )				
					Employee Meals		0	MARKETING/ADV/PROMO		118		
					Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC		1,585		
					EMPLOYEE BENEFITS - OTHER		1,794	LICENSES & PERMITS		328		
					EMPLOYEE PHYSICAL EXAMS		0	DUES & SUBSCRIPTIONS		3,266		
					PENSION/PROFIT SHARING PLANS		0	MGMT CO ALLOCATION		205		
TOTAL (agree to Schedule V, line 17, col. 1)				\$ 47,962	CHICAGO HEAD TAX		0	TRUST/FRANCHISE/CONTRIB/ETC		(1,585)		
(List each licensed administrator separately.)					INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense		( 0 )		
B. Administrative - Other								Non-allowable advertising				(118)
Description				Amount	INSURANCE - EXECUTIVE LIFE VI 21		0	Yellow page advertising		( 0 )		
MELVIN SIEGAL		MANAGEMENT FEES		\$ 3,000	TOTAL (agree to Schedule V, line 22, col.8)		\$ 132,335	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 4,242		
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 3,000	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
(Attach a copy of any management service agreement)												
C. Professional Services												
Vendor/Payee		Type		Amount	Description		Line #	Amount	Description		Amount	
GARY A. WEINTRAUB		LEGAL FEES		\$ 3,188					Out-of-State Travel		\$	
BURNSIDE, JOHNSTON		LEGAL FEES		218								
KRUPNICK, BOKOR, KAGDA		ACCOUNTING FEES		9,800								
PERSONNEL PLANNERS		U.C. CONSULTANT		538					In-State Travel			
LTC SOLUTIONS, INC.		DATA PROCESSING		1,320							0	
ALPHA DATA SERVICES		DATA PROCESSING		1,650					MGMT CO ALLOCATION		3,923	
BEST SOFTWARE OF CALIF.		DATA PROCESSING		457								
NURSING CARE SYSTEMS		DATA PROCESSING		4,417					Seminar Expense			
MAVIN ENTERPRISES LTD		BOOKKEEPING/ADMIN		60,061							0	
SAK MANAGEMENT SERVICES		BOOKKEEPING/ADMIN		774								
MAVIN ENTERPRISES LTD		ADMIN. CONSULTANT		4,632								
									Entertainment Expense		( )	
TOTAL (agree to Schedule V, line 19, column 3)					TOTAL		\$		(agree to Sch. V, line 24, col. 8)			
(If total legal fees exceed \$2500 attach copy of invoices.)				\$ 87,055					TOTAL		\$ 3,923	
				* Attach copy of IMRF notifications				**See instructions.				





## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL COUNCIL OF LONG TERM CARE \$3.266
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 43,372  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? \_\_\_\_\_ Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees